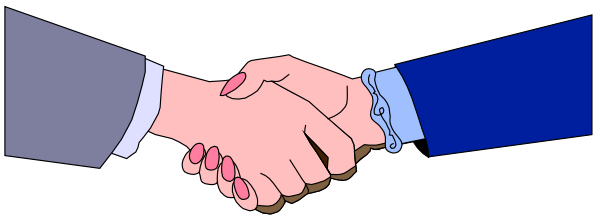
# NURSING HOME GUIDELINES

- INCIDENT IDENTIFICATION
- INVESTIGATION
- REPORTING

**PARTNERS IN PREVENTION**



June 2001

**Third Edition**

# Table of Contents

# CHAPTER I

## INTRODUCTION

This document contains guidelines for investigating, determining, and reporting incidents of nursing home resident abuse, neglect, mistreatment, injuries of unknown source, exploitation, or misappropriation of resident property. It also contains portions of:

- Chapter 74.34 Revised Code of Washington (RCW), Abuse of Vulnerable Adults;
- Sections of the Code of Federal Regulations (CFR) Part 483 – Requirements for State and Long-Term Care Facilities;
- CFR Part 488 – Survey, Certification, and Enforcement Procedures; and
- Chapter 388-97 Washington Administrative Code (WAC) – Nursing Homes.

These guidelines are intended to assist facilities in establishing policies and procedures to help prevent mistreatment, neglect, exploitation, abuse of residents, and misappropriation of resident property by any person. Policies and procedures should assure the facility staff does everything reasonably to protect residents.

These guidelines also contain general information to help determine if abuse, neglect, negligent treatment, mistreatment, exploitation, a reportable injury of unknown source, or misappropriation of resident property is likely to have occurred. The guidelines may be used for staff training.

Policies should be established for the employment of new staff members, volunteers, and students. It is the responsibility of the nursing home to:

- Check the OBRA Nurse Aide Registry to ensure OBRA certification, prior to the employment of a nursing assistant;
- Conduct criminal history background checks on staff, volunteers, and students who have unsupervised access to vulnerable adults, within 72 hours of conditional employment;
- Ensure all staff including agency-contracted personnel, are free of any disqualifying criminal history.

Questions about the guidelines may be sent to the attention of the Complaint Resolution Unit, Aging and Adult Services Administration, PO Box 45600, Olympia, Washington 98504-5600, or by calling the appropriate RCS Field Manager.

# CHAPTER II

## PURPOSE

The guidelines that follow are intended to assist nursing homes in complying with the requirements of the Vulnerable Adult Act, Chapter 74.34 RCW, and the Omnibus Budget Reconciliation Act (OBRA), 1987.

The guidelines are intended for use primarily by:

- Nursing Homes and nursing home employees;
- Department of Social and Health Services (DSHS) employees;
- Health professionals.

Other individuals or agencies that may want to utilize these guidelines include:

- Residents and families;
- Law enforcement agencies;
- Community agencies and concerned citizens;
- Long Term Care Ombudsman staff and volunteers.

The guidelines provide:

- General information to be applied in determining whether abuse, neglect, exploitation, or misappropriation of resident property has occurred;
- The nursing home's responsibility in reporting, investigating, and taking appropriate corrective and preventative measures;
- The responsibilities of the department and law enforcement agencies for receiving reports, investigating incidents of abuse or neglect, investigating individuals suspected of resident abuse, neglect, exploitation, or misappropriation of resident property, and the provision of protective services;
- The rights and responsibilities of persons reporting to DSHS Complaint Resolution Unit.

# CHAPTER III
**DEFINITIONS**

This chapter contains the definitions of the most frequently used words in the process of nursing home abuse/neglect identification, reporting, and investigation. Also included are various guidelines and comments. Examples correlating to the definitions are provided. These examples should not be considered all-inclusive, nor are they mutually exclusive. This chapter also contains both legal references and state and federal guidelines.

| Definitions | Guidelines & Comments | Examples |
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| **"ABANDONMENT"** as defined in RCW 74.34.020(1) means an action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care. | | |
| **"ABUSE"** as defined in 42 CFR 488.301, means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish.<br><br>The federal guidelines in the State Operation Transmittal #10, pp-48, "Survey Procedures for Long Term Care Facilities" also include in the definition of abuse the willful deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.<br><br>******See also Appendix A for Abuse Definition Diagram<br><br>**"ABUSE"** as defined in RCW 74.34.020(2) means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual | The obligation of nursing homes is to protect the health and safety of every resident, including those that are incapable of perception or who are unable to express themselves.<br><br>In general, it must be presumed that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident.<br><br>This means that instances of abuse of any resident, (whether comatose, cognizant or not), cause physical harm, pain, or mental anguish.<br><br>The term "*willful"* describes the non-accidental action or inaction that resulted in the abuse of the resident. The term does not mean that an individual intended to cause harm, pain, anguish, or injury. Instead, it means that the individual intended the action or inaction itself that he/she knew or should have known could cause harm, anguish, pain, or injury.<br><br>Willful inaction includes, but is not limited to, a refusal to provide the necessary "care" and required services, & intentional deprivation. | **EXAMPLES OF ABUSE** may include, but are not limited to, the following:<br><br>▪ **Verbal abuse:** Any use of oral, written or gestured language that willfully includes threats and/or disparaging & derogatory terms to or about residents or their families, within hearing distance of any resident regardless of their age, ability to comprehend, or disability; |

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| abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:<br><br>▪ **Sexual abuse** means any form of non-consensual contact, including but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving services from a program authorized under chapter 71A.12 RCW, whether or not it is consensual<br><br>▪ **Mental abuse** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.<br><br>▪ **Physical abuse** means the willful action of inflicting bodily injury or physical mistreatment. | Physical contact with a resident for the purpose of retaliating against that resident, even in response to a physical attack or verbal abuse from a resident, is never justifiable and constitutes abuse.<br><br>Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. Refer also to State Operations Transmittal #10, pp-49 for further guidelines related to involuntary seclusion. | threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.<br><br>▪ **Involuntary Seclusion:** isolating a resident against the resident's will or will of legal representative by leaving him/her in their room or other isolated location.<br><br>▪ **Willful deprivation by inaction**: refusal of staff to intervene, such as when a resident who is taking a bath has been left there for quite a while, is getting cold and upset, needs assistance getting out of the tub, sees the caretaker and asks for help. The caretaker refuses, walks away and does not tell anyone.<br><br>▪ **Sexual Abuse:** Inappropriate touching, sexual harassment, sexual coercion, or sexual assault.<br><br>▪ **Mental Abuse:** humiliation, harassment, threats of punishment or deprivation, purposely withholding cigarettes or some form of entertainment, or something that is rightfully the resident's, or placing any unreasonable restrictions on the resident's mobility or ability to communicate with other persons either verbally or in writing.<br><br>▪ **Physical Abuse:** Hitting, slapping, prodding, poking, or sticking a resident with a sharp object, pushing, shoving, spitting, twisting, squeezing, pinching, and kicking. It also |

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| Physical abuse includes, but is not limited to striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.<br><br>▪ **Exploitation** means "an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another".<br><br>**See also the definition of "Misappropriation of Resident Property" (pg 9) and "Financial Exploitation" (pg 7). In some situations these terms may be used interchangeably. | In addition to theft or outright taking of resident property, exploitation may involve tricking the resident into signing a document or giving consent regarding matters involving property or finances, through the use of manipulation, deception, or keeping the vulnerable adult ignorant of important facts about their money, property, or other resources. Compromised mental or physical capacity may make a resident more susceptible to deception, undue influence or pressure. | includes controlling behavior through corporal punishment, such as purposely withholding food and medications.<br><br>**Exploitation:** may include, but are not limited to, the following:<br>▪ Any individual who sells the resident's property, house, or other valuables for their own personal gain or profit;<br>▪ Surrogate decision maker or payee who has been given fiduciary responsibility by the resident to pay the nursing home bill, is refusing to meet the resident's needs by using the resident's money or asset for his or her personal profit or gain;<br>▪ Any individual who for personal profit or advantage coerces the resident to sign a document, contract, legal form, or any other form designating authority over the resident's finances and property;<br>▪ Any individual who uses the resident's name or credit status to obtain personal credit;<br>▪ Surrogate decision maker or payee does not pay into the resident's trust fund account and does not provide for the resident's personal needs, but uses the money to buy their own items or pay personal bills. |
| **"ACCIDENT"** as defined in the State Operations Transmittal #10, page pp-105, means an **"unexpected, unintended event that can cause a resident bodily injury."** | Foreseeable incidents are not accidents.<br><br>42 CFR 483.10(b)(11) and WAC 388-97-07010(1) require that nursing homes immediately inform the resident; consult with the resident's physician; and if known, notify the resident's surrogate decision maker when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.<br><br>42 CFR 483.25(h)(1)&(2) states that the facility must ensure that the resident environment remains | **Examples of accidents** may include, but are not limited to, the following:<br>▪ A self-propelling resident catches a finger in wheelchair spoke and fractures the finger.<br>▪ An independent resident who becomes dizzy fails to use call light for help and falls while getting out of bed.<br>▪ Resident pinches hand in doorjamb and sustains a skin tear.<br>▪ Resident hits arm on the head of the bed and sustains a bruise on forearm. |

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| | as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. F tags 323 & 324.<br><br>Accidents do include equipment or mechanical failures that were not known prior to the use of the equipment. Routine preventative maintenance is important to prevent accidents. | Any of the above examples <u>may</u> become examples of neglect if repeated without facility intervention, or if the prior risk of such an event was identified and no action was taken to prevent the occurrence. |
| **"BODILY HARM"** as defined in RCW 9A.04.110(4) means physical pain or injury, illness or an impairment of physical condition. | | |
| **"FINANCIAL EXPLOITATION"** as defined in RCW 74.34.020(6) means the "illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage".<br><br>******See also the definition of "Misappropriation of Resident Property" (pg 9) and "Abuse - Exploitation" (pg 6). In some situations these terms may be used interchangeably. | | |
| **"INCIDENT"** For the purposes of these guidelines, an incident means:<br><br>▪ An occurrence involving a resident in which mistreatment, neglect, abuse, misappropriation of resident property or exploitation are alleged or suspected; or<br><br>▪ A substantial injury of unknown source, or cause, or circumstance | All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury results from abuse or neglect. <u>It may not always be possible to determine the cause of the incident.</u><br><br>The purpose of adding the definition of "*incident*" to these guidelines is to assist in identifying when a facility must do a thorough investigation. Not all occurrences that happen to residents are incidents that require an investigation. For example, superficial injuries of unknown source and some falls when **abuse or neglect is not alleged or suspected**, do not require a thorough investigation, but do require assessment to assist in preventing reoccurrence.<br><br>An ***allegation*** is a statement or a gesture made by someone | **EXAMPLES OF INCIDENTS** may include, but are not limited to, the following:<br><br>▪ Any occurrence that is not consistent with standards of care and practice;<br>▪ Substantial injury of unknown source;<br>▪ Any allegation of mistreatment, neglect or abuse; *and*<br>▪ Any misappropriation of resident property or exploitation of a resident. |

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| | (regardless of capacity or decision-making ability) that indicates that abuse, neglect, exploitation, or misappropriation of resident property may have occurred and requires a thorough investigation.<br>To ***suspect*** means to have reason to believe without conclusive proof that someone may have abused, neglected, exploited a resident, or misappropriated a resident's property.<br><br>Documentation of the investigation for all incidents and the determination of "reasonably related" must be kept and readily available for state review, internal risk management, and federal authorities. | |
| **"INJURIES OF UNKNOWN SOURCE"** means any injury sustained by a resident where the source of the injury was<br>▪ Not observed directly by a staff person –*or* –<br>▪ Through the process of assessment for a superficial injury – *or* –<br>▪ Through the process of a thorough investigation for a substantial injury,<br>▪ The injury was determined to not be reasonably related to the resident's condition, diagnosis, known and predictable interaction with surroundings or related to a known sequence of prior events.<br><br>Injuries of unknown source may be either <u>superficial</u> or <u>substantial</u> in nature.<br><br>**Types of injuries of unknown source**: | It is not always possible to determine the cause of the injury. | |
| ▪ **Superficial injury** of unknown source shall include injuries which are limited to the surface layers of the skin, would be easily treated with first aid, would not require physician's orders for treatment (such as sutures or diagnostic x-rays); **<u>and</u>** are located in areas generally vulnerable to trauma. | Superficial injuries of unknown source that are not incidents of suspected or alleged abuse or neglect must be assessed to determine the cause and appropriate corrective action must be taken. Documentation of the assessment must be in the resident's clinical record. | **Examples of superficial injury** may include, but are not limited to, the following:<br>▪ Small abrasions, lacerations, or bruises limited to the surface layers of the skin, occurring in areas generally vulnerable to trauma, such as hands, forearms, and shins; |

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| ▪ **Substantial injury** of unknown source shall include those injuries greater than superficial that would require more than first aid and may require close assessment and monitoring by nursing or medical staff; or those injuries occurring in areas not generally vulnerable to trauma. | All substantial injuries of unknown source must be thoroughly investigated. All injuries (regardless of the extent) occurring in non-vulnerable areas shall be considered substantial injuries. | **Examples of substantial injury** may include, but are not limited to:<br>▪ Abrasions, burns, deep lacerations, bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;<br>▪ All fractures |
| **"MANDATED REPORTER"** as defined in RCW 74.34.020(8) is an employee of the department; law enforcement; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW | | |
| **"MISAPPROPRIATION OF RESIDENT PROPERTY**" as defined in 42 CFR 488.301 means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.<br><br>**See also the definition of "Abuse – Exploitation" (pg 6) and "Financial Exploitation" (pg 7). In some situations these terms may be used interchangeably. | Refer also to State Operation Transmittal #10, pp-50 for further guidelines.<br><br>Residents with cognitive impairments that are known to misplace/take other resident's belongings as part of their regular behavior are not considered to be misappropriating other resident's items. | **Examples of misappropriation of resident property** may include, but are not limited to, the following:<br><br>▪ Facility staff or others take resident money or property without permission of the resident;<br>▪ Facility staff or others "borrow" clothing or other property of one resident to lend to another resident (this behavior could range from improper use of resident clothing to lending a resident's TV or wheelchair to another resident);<br>▪ Facility staff use disposable briefs, disposable gloves, and other expendable items which were purchased by, or charged to a resident for another resident's use. |
| **"NEGLECT"** as defined in 42 CFR 488.301 means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. | In the definition of neglect, the words **"necessary to avoid physical harm, mental anguish, or mental illness"** mean that it is more probable than not that harm could happen to the resident because the goods or service | **Examples of neglect** may include, but are not limited to, the following:<br><br>▪ Failure to carry out orders for treatment, therapy, diagnostic testing, administration of |

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| **"NEGLECT,"** as defined in RCW 74.34.020(9), means:<br>(a) a pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or<br>(b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.<br><br>See also Appendix B for Neglect Definition Diagram (p. 26) and Appendix C for Medication Error Decision Tree (p. 27) | were not provided.<br><br>Neglect may be determined even if no apparent negative outcome has occurred. According to HCFA comments in the Federal Register (November 10, 1994, Vol. 59, No. 217) neglect may include instances where no apparent negative outcome has occurred, but the likelihood for deterioration of the resident's physical, mental, or emotional condition exists.<br><br>The likelihood for negative outcome must be considered. For example, a staff member who fails to administer a resident's afternoon nourishment has failed to provide goods. However, one would need to consider the resident's condition before a determination could be made if this one time omission would "likely" result in harm to the resident.<br><br>Neglect does not include failure to provide treatment or service that a resident has, with consent, refused. In addition, the definition of "neglect" does not include the element of intent to do harm by a provider or caregiver.<br><br>In general, neglect occurs with failure to follow accepted standards of practice in accordance with the staff person's relevant knowledge base or training, which leads to harm or is known to cause harm to the resident. Serious disregard of consequence means that the individual actually had knowledge, or should have known (based on training or educational background), that the act committed or omitted was a clear and present danger to the resident's health, welfare, or safety; or that the act was committed or omitted with reckless disregard of its clearly dangerous consequences. | medications, absent refusal by resident;<br>▪ Failure to carry out the resident's plan of care;<br>▪ Failure to answer a resident's call light or bell in a reasonable time frame;<br>▪ Being left to sit or lie in urine or feces;<br>▪ Failure to adequately supervise the whereabouts and/or activities of a resident;<br>▪ Failure to feed or assist a dependent resident who requires help with eating.<br>▪ Failure to withhold resident's digoxin when resident clearly displayed signs and symptoms of digoxin toxicity & the resident's digoxin blood level indicated a toxic level;<br>▪ Passing medications "by memory";<br>▪ Failure to report a resident's chest pain and shortness of breath to supervising staff;<br>▪ Failure of dietary staff to refrigerate meat and resident(s) acquire(s) "food poisoning";<br>▪ Allowing the physical environment to deteriorate to the point that residents are subject to hazardous situations, such as electrical, water, and structural hazards;<br>▪ Failure to transfer a resident in need of emergency help out of the facility when the resident's condition clearly warrants the transfer and the resident's health, safety or welfare is dependent upon emergency intervention;<br>▪ Failure to consult with a resident's attending physician when resident's condition requires medical intervention;<br>▪ Failure to assess and evaluate a resident's status or failure to institute nursing interventions as required by the resident's condition which results in harm to the resident or demonstrates a clear and present danger for harm;<br>▪ Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals which can or does result in weight loss patterns or other |

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| | | parameters of poor nutritional status that are not the result of a medical condition. |
| **"PERMISSIVE REPORTER"** as defined in RCW 74.34.020(10) means any person, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults. | | |
| **"REASONABLE CAUSE TO BELIEVE"** means a mandated reporter thinks it is probable that an incident of abuse, abandonment, neglect, or financial exploitation happened. Probable means that, based on information or evidence readily obtained from various sources, it is likely the incident occurred. Sources of information may include:<br>▪ Personal observation of the incident;<br>▪ Resident who is subject of incident;<br>▪ Incident logs, medical records, etc.<br>▪ Other persons who may have relevant information;<br>▪ Resident behavior;<br>▪ Other relevant information.<br>A reporter may rely upon one or more of the above sources. | RCW 74.34.035 requires that when there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred – mandated reporters shall immediately report to the department. | **Examples of reasonable cause to believe** may include, but are not limited to, the following:<br>▪ Finger or slap marks on a resident;<br>▪ Resident without a history of making allegations of abuse states that a staff member has abused her or treated her poorly (this does not mean that other residents who have a history of making allegations should not be taken seriously and the facility must report all allegations of abuse);<br>▪ Any physical evidence of rape such bruising in the perineal area, vaginal tears, abnormal redness or bleeding in the vaginal area, etc.;<br>▪ Resident demonstrates fear in the presence of a particular caregiver or other people. |
| **"REASON TO SUSPECT"** as defined in RCW 74.34.035 means a mandated reporter thinks, based on information readily obtained from various sources, it is possible that an incident of sexual or physical assault could have happened. Sources of information may include:<br>▪ Personal observation of the incident;<br>▪ Resident who is subject of incident;<br>▪ Incident logs, medical records, etc.<br>▪ Other persons who may have relevant information;<br>▪ Resident behavior;<br>▪ Other relevant information.<br>A reporter may rely upon one or more of the above sources. | RCW 74.34.035 requires that when there is reason to suspect that sexual or physical assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department. | |

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| **"REASONABLY RELATED"** means a prudent person acting with professional knowledge, guided by community and professional standards, and with knowledge of facts and circumstances as established during a thorough investigation, (or by assessment of superficial injuries of unknown source which are not incidents of suspected or alleged abuse or neglect), has good reason to believe that the source of the injury is reasonably connected to the facts and circumstances surrounding the resident. | Facts and circumstances surrounding the resident may include, but are not limited to the following: their diagnosis; medication regimen; expected or known results of a medical or diagnostic procedure; their functional abilities; and the resident's normal interaction with their environment. | **Examples of reasonably related** may include, but are not limited to, the following:<br><br>▪ Normal bruising that results from venipuncture or other parenterally invasive procedures;<br>▪ Skin tears related to fragile skin;<br>▪ Bruising in generally vulnerable areas related to certain drug usage such as anti-coagulants or prolonged steroid usage, or bruising associated with other medical conditions such as leukemia. |
| **"VULNERABLE ADULT"** as defined in RCW 74.34.020(13) includes a person:<br><br>▪ Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or<br>▪ Found incapacitated under Chapter 11.88 RCW; or<br>▪ Who has a developmental disability as defined under RCW 71A.10.020; or<br>▪ Admitted to any facility, or;<br>▪ Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under Chapter 70.127 RCW; or<br>▪ Receiving services from an individual provider. RCW 74.34.020 | | |

# CHAPTER IV

**INVESTIGATION PROCESS BY NURSING HOMES**

All alleged incidents require a thorough investigation in an attempt to determine what occurred and to make changes, as needed, to prevent reoccurrence. A thorough investigation is a systematic (consistent and ordered) collection of information (evidence) that describes and explains an event or a series of events. The investigation seeks to determine if abuse, neglect or misappropriation of resident property occurred, and to determine how an incident occurred to prevent further occurrences.

Critical components of any investigation include:

A. The timeliness of the initiation of the investigation;
B. The thoroughness of the investigation; and
C. The objectivity of the investigator

## A. THE TIMELINESS OF THE INVESTIGATION

Staff is expected to immediately report any unusual events and initiate investigations in accordance with facility policy. Facility training of staff and written policies are required to help organize and allow the investigative process to proceed in a smooth and expeditious manner. Policies should define the responsibilities of staff who conduct investigations.

A prompt response to a reported incident is imperative to accurate data collection. Any delay in beginning the investigation can cause valuable information to be lost or altered.

Concurrently, without delay, the nursing home must take appropriate action to treat all consequent ill effects experienced by the resident(s) from the alleged incident(s) and to safeguard the resident(s) from reoccurrence.

## B. THE THOROUGHNESS OF THE INVESTIGATION

A thorough investigation is intended to allow the nursing home to identify and document who was involved in the incident and what, when, where, why, and how the incident happened, including the cause or reasonable cause of the incident. It will also determine if allegations are substantiated, unsubstantiated or unknown.

In general, the amount of time and resources necessary for an investigation will vary depending on the nature of the allegation or incident. It is the quality of the investigation that is most important, not the quantity (amount) of documentation.

A thorough investigation requires the review of the following questions. Each phase has the following two steps: 1. data collection, and 2. data analysis.

**Data Collection**: These examples are not all inclusive and need to relate to the type of incident that is being investigated.

WHO: Who is (are) the alleged suspect(s) or who may have contributed to the occurrence of the incident?
Who is (are) the alleged victim(s)?
Who spoke to the alleged victim(s) regarding the incident?
Who witnessed the incident?
Who may have information related to the incident?

WHAT: What is the incident?
What is the chronological order of action leading up to the alleged incident?
What are the injuries?
What information does the alleged victim have regarding the incident?
What did the discovering person or witness see, hear or smell?
What did these people do in relation to first discovering the incident?
What information do other staff members have of the incident or factor(s) leading up to the incident?
What was the functional, mental and cognitive status of the alleged victim before and after the incident?
What is known about the alleged suspect(s) or person(s) who may have contributed to the occurrence of the incident?

WHEN: When did the incident occur? (be specific as possible)

WHERE: Where did the incident occur? (exact location if known)

**Data Analysis**: Analysis will establish: 1. reasonable cause, 2. Need for further investigation, or 3. Inability to determine the cause.

HOW/WHY: Summarize analysis of facts gathered that either establish reasonable cause for the incident or establish need for further investigation.
How did the incident occur?
How was this incident avoidable? (Were there factors that made this incident unavoidable?)
Why did the injury or incident occur?

A thorough investigation may require two phases of fact gathering. The first phase is to be completed within 24 hours of knowledge of the incident. The extended or second phase may follow, depending upon the success of the first phase.

# PHASE ONE: INITIAL INVESTIGATION

May include the following elements depending upon the incident.

NOTE: The listing of the following elements does not mean that every element must be included in each investigation. Only the elements that are appropriate to the circumstances surrounding the incident should be considered. In addition, for some incidents with injuries when abuse or neglect is not suspected, but the injury is of unknown cause, the cause may be determined to be reasonably related to the medical and/or functional condition of the resident, and therefore it would not be necessary to complete other investigative elements.

- Interview the alleged resident victim
- Interview witnesses, including:
  - ✓ Assigned caregiver
  - ✓ Caregivers in immediate area
  - ✓ Remote or potential witnesses, such as visitors, family, roommates
  - ✓ Alleged perpetrator
- Review the resident victim's medical condition
- Review the resident victim's normal interaction with the environment
- Observe environment where incident was likely to have occurred
- Review of the resident victim's plan of care
- Assess current cognitive status of victim
- Physical exam
- Diagnostic work, if needed
- Comprehensive record review, which may include the following elements depending on the nature of the incident:
  - ✓ Progress notes
  - ✓ Flow sheets and care plans
  - ✓ Physician orders
  - ✓ Laboratory results
  - ✓ Assessments: MDS, RAPs, and other assessments
  - ✓ Social and psychological history
  - ✓ Diagnosis/problem list
  - ✓ Injury trends, similar incidents and injuries, related quality assurance system documents
- See also: "Preservation of Evidence" on Page 17.

If the first phase of investigation allows the investigator to answer and document "who, what, when, where, why, and how" and therefore establish a reasonable cause or known source of the incident or injury within 24 hours of the incident or injury, an extended investigation is not required. However, if the investigator is unable to establish reasonable cause or known source, further investigation is required.

Immediate telephone reporting is required for abuse, neglect, exploitation and misappropriation.

Substantial injuries of unknown source must be reported within 24 hours.

## PHASE TWO: EXTENDED INVESTIGATION (After the first 24 hours)

Further investigation is required if the first phase of the facility investigation did not establish reasonable cause or source of allegation or injury within 24 hours. The following elements may be included:

- Interviews of expanded sample of witnesses, historians
- Expand the time frame surrounding the incident
- Follow up on new information
- Obtain related professional expertise
- If suspected perpetrator is staff, interview assigned residents.
- See also: "Preservation of Evidence" on Page 17.

Documentation should allow the investigator to answer "who, what, when where, why and how" leading to the establishment or reasonable cause or known source of allegation or injury, if possible. If cause or reasonable cause cannot be established in either investigative phase, the cause is reported as unknown.

Extended investigation findings must be entered into the Reporting Log and available within five days of the discovery of the incident or injury. The entry may require updating as the investigation progresses to completion. See Pages 18-24 for reporting requirements. Refer also to Appendix A and B (Algorithms for Abuse and Neglect).

## C. OBJECTIVITY OF THE INVESTIGATOR

The investigator of any incident must remain objective and maintain neutrality during the course of the investigation. Investigations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property should not begin with a presumption of guilt or innocence of an individual(s), but should start with a "ruling out" of the fact that abuse, neglect, mistreatment, exploitation, or misappropriation of resident property could have occurred. The investigator should approach the investigation from an impartial perspective regarding the incident and collect accurate, appropriate data to come to a reasonable conclusion.

**CORRECTIVE ACTION REQUIRED FOLLOWING THE INVESTIGATION:**

After the investigative phases are completed, the nursing home is required to take action based on the investigative findings to correct the known and reasonable causes as well as to prevent further reoccurrence of the alleged incident(s).

**DOCUMENTATION OF FIRST AND EXTENDED INVESTIGATION:**

Documentation must be readily available to state licensing and certification staff and others according to their authority. This documentation may in the format and location selected by the facility.

Documentation of the investigation should contain information and facts that address who, what, when, where, how and why of the incident. Documentation of incidents that are related to a resident's medical condition should provide enough information to identify the nature of the injury and the facts that relate the injury to the condition of the resident.

All documentation related to the investigation of incidents must be retained for the period of three years. (This does not apply to documentation of incidents in the resident's clinical record, which must be retained for a period of eight years.) (RCW 18.51.300)

**PRESERVATION OF EVIDENCE:** RELEVANT EVIDENCE IDENTIFIED DURING THE COURSE OF THE INVESTIGATION MUST BE PRESERVED.

Preservation of evidence is especially important when dealing with criminal or more serious incidents. Evidence collected during the investigation may include the following:

1. Testimonial evidence;
2. Documentary evidence;
3. Physical evidence; and
4. Demonstrative evidence.

Statements should be written, signed, and dated by the individual providing the testimony. Testimonial evidence should be collected on a one-to-one basis, and as soon as possible after an incident, to avoid contamination of the evidence. The person receiving the statement should also sign and date the document. Blank areas on the paper should be crossed out and initialed.

Documentary evidence (such as laboratory results, progress notes, flow charts, etc.) should be copied and attached to the investigative report. Any direct evidence such as resident clothing, linen, or the scene in which the incident occurred should be preserved until the evidence has been thoroughly analyzed, photographed, or provided to law enforcement.

Demonstrative evidence such, as pictures of bruising or a drawn diagram of the room, should also be attached to the investigative report.

# CHAPTER V

**MANDATORY REPORTING REQUIREMENTS**
**24 hour Hot Line 1-800-562-6078**

## REPORTING OF ABUSE IN NURSING HOMES

Protecting the resident from further harm is the first priority. Reporting is the second priority. These guidelines do not exempt a person from determining the most prudent course of action to be taken to report the incident and protect a vulnerable adult.

**Who is a mandated reporter?**

A MANDATED REPORTER IS: RCW 74.34.020, "Abuse of Vulnerable Adults statute, states that a mandated reporter is an employee of the department; law enforcement officer, social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social services, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian science practitioner; or health care provider subject to Chapter 18.130 RCW."

For the purposes of reporting abuse, abandonment, financial exploitation, sexual abuse and physical abuse, the person mandated to report is:

- An employee/operator who observes the incident or hears the victim state it happened.
- An employee/operator who hears about an incident from a permissive reporter who has direct knowledge of the incident.
- The employee's supervisor or facility designated person receiving the information from the mandatory reporter.

A permissive reporter is any person, including but not limited to, an employee of a financial institution, attorney, volunteer, family and other visitors.

The person who does not have to report is an employee other than the employee's supervisor or facility designated person who hears about the incident from a mandated reporter and who believes that the report has been made.

**Where to report?**

- To report abuse, abandonment, neglect, financial exploitation, misappropriation of resident property, injuries of unknown source and sexual abuse or physical abuse, call the department's hotline number 1-800-562-6078. The number is available 24 hours a day, seven days a week and the time and date of messages are recorded.

- To report to law enforcement, use the local number as specified by your local law enforcement authorities. Of course if it is an emergency, call 911 or the emergency services number.

**What is to be reported?**

- When the individual mandated reporter has reasonable cause to believe an incident is abuse, abandonment, neglect, or financial exploitation, he/she must report to the department. RCW 74.34

    - Reasonable cause has also been defined as "a belief that the incident probably happened" based upon personal observation of the victim, records other people and other relevant information.

- When the individual mandated reporter has reason to suspect an incident is sexual abuse or physical abuse, he/she must report to the department and law enforcement. RCW 74.34

    - Reason to suspect has also been defined as "a belief that the incident could have happened" based upon observations and information.

    - Sexual abuse includes but is not limited to unwanted inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, and sexual relations between a resident and a staff member.

    - Physical abuse includes the attempt to injure another person, unlawfully touching another person or action that causes fear of harm in another person. (An incidental push or gentle contact may not be an abuse unless the person intended to do harm or create fear.)

- When there is reasonable cause to believe a crime has occurred it must be reported immediately to both the department and to local law enforcement.

- Federal law requires nursing homes to report "All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property". 423 CFR 483.13 (this applies to the facility reporter only)

  Injuries of unknown source means the source of the injury was not observed directly by a staff person or identified through the process of assessment for asuperficial injury or the process of a thorough investigation for a substantial injury.

**When does the report have to be made?**

- When a mandated reporter has reason to suspect an incident is sexual abuse or physical abuse, he/she must report as soon as the resident/victim is protected from further harm.

- When a mandated reporter has reasonable cause to believe an incident is abandonment, abuse, neglect or financial exploitation, the report must be made immediately.

- If the incident involves licensed professionals, the facility must also report to professional licensing in the Department of Health, within 24 hours.

- When anyone makes an allegation of abandonment, mistreatment, abuse, neglect or misappropriation of a resident's property, the facility must immediately report to the department by phone.

- Within five days of discovery, the facility must complete an entry in the reporting log or medical records, all incidents, injuries and allegations involving abandonment, mistreatment, neglect, abuse or exploitation, including misappropriation of resident property, and injuries of unknown source.

**What is reported for incidents involving Resident To Resident?**

For resident to resident abuse, financial exploitation, sexual abuse or physical abuse:

<u>Report to the department:</u>

- Incidents resulting in psychological harm to the resident/victim
- Sexual abuse
- Physical abuse

<u>Report to law enforcement:</u>

- Sexual abuse
- Physical abuse with injury

**What information should be included in a mandated reporter's report?**

The law states that each report, oral or written, must contain as much as possible of the following information:

1. The name and address of the person making the report;
2. The name and address of the vulnerable adult and the name of the facility providing care;
3. The name and address of the legal guardian or alternate decision maker;
4. The nature and extent of the abandonment, abuse, financial exploitation, neglect or self-neglect;
5. Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect;
6. The identity of the alleged perpetrator, if known, and;
7. Other information that may be helpful in establishing the extent of abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult. RCW 74.34.025(4) (a) through (g)

**Is the identity of the person making a mandated report confidential?**

The identity of the person is kept confidential unless that person consents or there is a judicial proceeding. RCW 74.34.095 (1) through (3)

**Can I, as a mandated reporter, be terminated, suspended or disciplined by my employer if I make a good faith report of abuse, neglect, abandonment, or financial exploitation to the department or law enforcement if I report?**

No, as long as the report is made in good faith. You may, however, be terminated, suspended, or disciplined by your employer for other lawful purposes RCW 74.34.180(3).

**If a resident, family member, visitor or other person makes a complaint of abuse, neglect, abandonment or financial exploitation on behalf of another resident or on behalf of him or herself, can a resident be discharged from the facility for having made a complaint?**

No, as long as the department has substantiated the complaint, neither the resident making the complaint, nor the resident who is the subject of the complaint, may be discharged from the facility. An action, by the facility, to discharge a resident who makes a complaint or who was the subject of a complaint, substantiated by the department within one year from the date a complaint was made, is presumed to be a retaliatory discharge, which is prohibited by law. The presumption that the discharge was motivated by the complaint may be disproved, and a discharge may therefore be permitted, by showing that the increased needs of the resident cannot be met by the reasonable accommodation of the facility or tha the discharge action was begun prior to the complaint having been filed. (RCW 745.34.180(1)&(2))

**What can happen if I don't report?**

"A person who is required to make a report under this chapter and who knowingly fails to make the report is guilty of a gross misdemeanor." RCW 74.34.053(1)

- Failure to report resident abuse or neglect is a crime and may be prosecuted.
- The penalties of a gross misdemeanor include fines of up to $5000 and/or one year imprisonment in jail.
- Licensing action may be taken by the appropriate professional licensing authority based upon non-reporting by those professionals of incidents of suspected abuse or neglect.

**What if I make a false report?**

You are guilty of a misdemeanor punishable by a fine of up to $1000 and up to 90 days in jail, if you make an intentional false report. RCW 74.34.053(2)

**If I report the incident to my supervisor, does that satisfy my reporting requirement?**

No, the law states that each employee is a mandated reporter; therefore, you must make the reporting call when you have reasonable cause to believe or reason to suspect the incident is reportable. To protect the victim from further harm, it is prudent for a facility to have policies and procedures in place that direct you to internally notify the responsible person. Procedures should state what you are to do if the person responsible for the incident is the person to whom you usually report. RCW 74.34.024

**Can my supervisor require that I tell her about the incident prior to making the reporting call?**

No, a facility cannot have a policy that interferes with mandatory reporting. However, you may wish to consult with that person in making the determination if you have reasonable cause to believe or reason to suspect the incident is reportable. RCW 74.34.035(3)

**What does it mean to protect the resident from further harm?**

Preventing the resident from further harm means keeping the resident safe. Each situation will be different. Here are some examples of actions that might be implemented:

- Assuring the alleged perpetrator is kept away from the resident or other residents;
- Having a trusted person stay with the resident;
- Allowing the resident to stay in an area he/she feels is safe (wellness center, nurses station)
- Safeguarding the resident's property.

# CHAPTER VI

**REPORTING REQUIREMENTS**
**OWNERS, OPERATORS AND MANAGERS**
**24 hour Hot Line 1-800-562-6078**

## REPORTING OF ABUSE IN NURSING HOMES

**What are owners, operators and managers or their designees required to report?**

Owners, operators and managers of facilities must also report as mandated reporters described in Chapter V in addition to the requirements outlined in this chapter.

- RCW 74.34.020, "Abuse of Vulnerable Adults statute, states that an operator of a facility is required to report abuse, abandonment, financial exploitation, sexual abuse and physical abuse.

  - ✓ CFR 483.13 "All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriations of residents property" must be reported to the department.

  - ✓ WAC 388-97-162(b) "Any event, actual or potential, requiring the evacuation of all or part of the nursing home's residents to another address" must be reported to the department.

  - ✓ WAC 388-97-162(c) "Circumstances which threaten the nursing home's ability to ensure continuation of services to residents" must be reported to the department.

  - ✓ WAC 388-97-042 (5)(a)(b) "The nursing facility must send a copy of the federally required transfer or discharge notice to:"

    - The department's home and community services when the nursing home has determined under WAC 388-97-037, that the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, and

    - The appropriate RCS Field Manager when the transfer or discharge is for any of the following reasons:

      - ∇ The resident's needs cannot be met in the facility;
      - ∇ The health or safety of individuals in the facility is endangered; or
      - ∇ The resident has failed to pay for a stay at the facility.

Unusual events, such as fire, explosion, missing residents, communicable disease outbreak, and any disaster should also be reported to the department.

**Where to report?**

- To report abuse, abandonment, neglect, financial exploitation, mistreatment, misappropriation of resident property, injuries of unknown source and sexual abuse or physical abuse, call the department's hotline number 1-800-562-6078. The number is available 24 hours a day, seven days a week and the time and date of the messages are recorded.

- To report to law enforcement, use the local number as specified by your local law enforcement authorities. Of course if it is an emergency, call 911 or the emergency services number.

- The Reporting Log: The facility must maintain a state Reporting Log (see Appendix E). The log must be retained in the facility and readily accessible at all times to state licensing and certification staff and others according to their authority. Minimally, the log must contain the information indicated on the model form seen at Appendix E, using the prescribed format and codes. Other information may be added if desired by the facility. Log entries shall be retained and preserved by the facility for a period of no less than three years.

**What is to be reported?**

- Substantial injuries of unknown source (not incident of suspected abuse or neglect) shall be reported by telephone to the department within 24 hours of initial discovery.

    - ✓ Injuries determined through the process of investigation to be reasonably related to the resident's condition, diagnoses, known and predictable interactions with surroundings, or a known sequence of prior events, are incidents that must be logged in the reporting log within five (5) days from discovery.

- Superficial injuries of unknown source (not incidents of suspected abuse or neglect) shall be reported by entry into the reporting log within five (5) days of discovery.

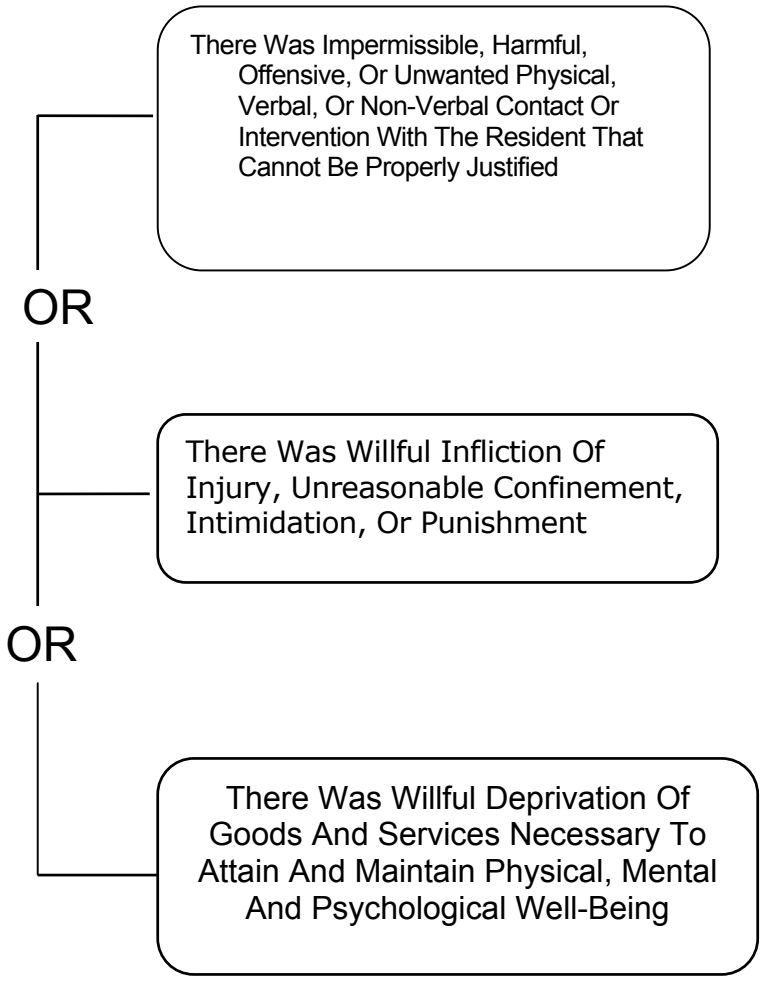
    - ✓ Superficial injuries determined by assessment to be reasonably related to the resident's condition, diagnoses, known and predictable interactions with surroundings, or known sequence of prior events, are incidents that do not require reporting.

- When there is reasonable cause to believe a crime has occurred, it must be reported immediately to both the department and to local law enforcement.

Refer to Chapter V for additional reporting obligations as mandated reporters.

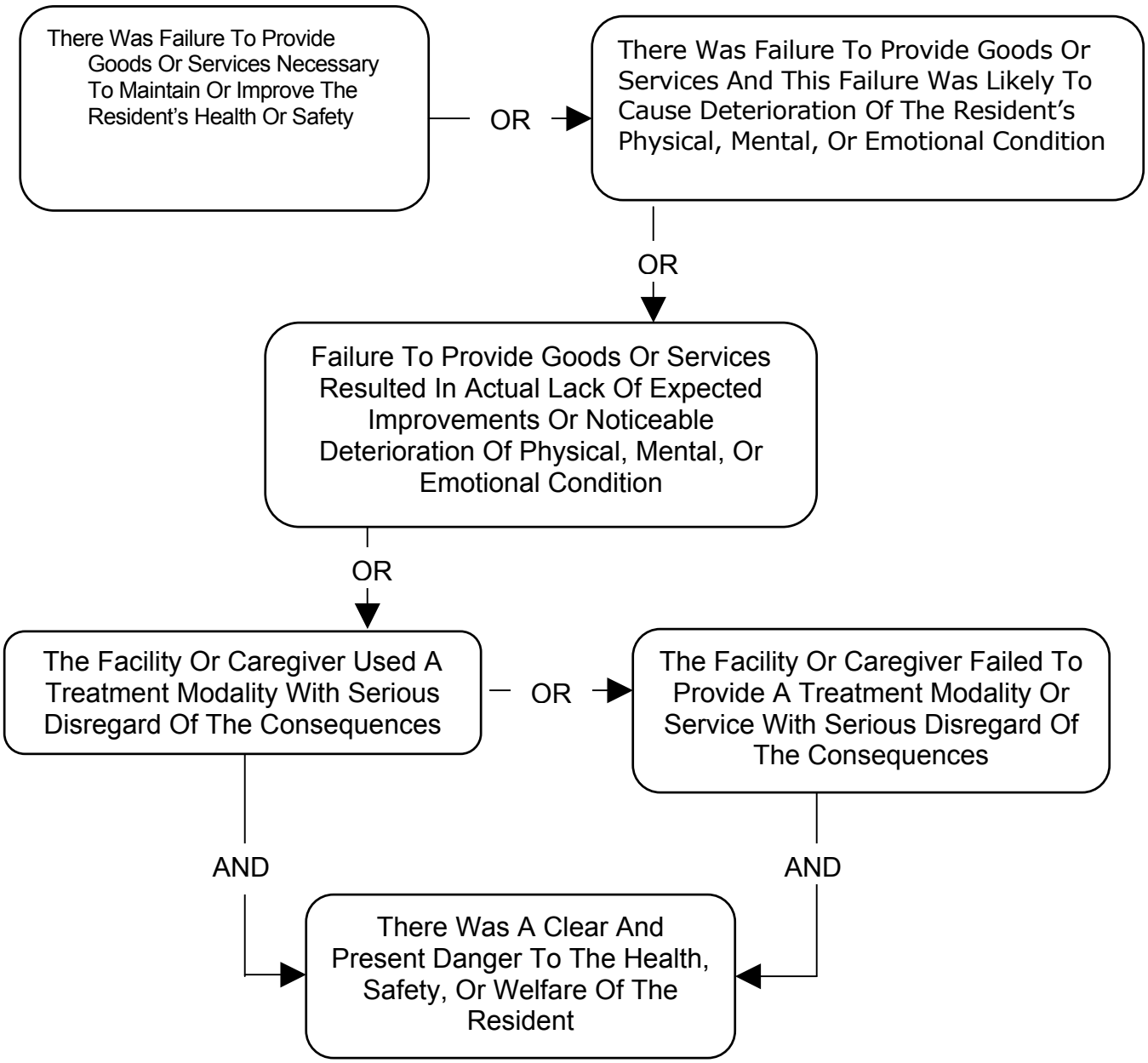
# APPENDIX A

**DEFINITION DIAGRAM - ABUSE**



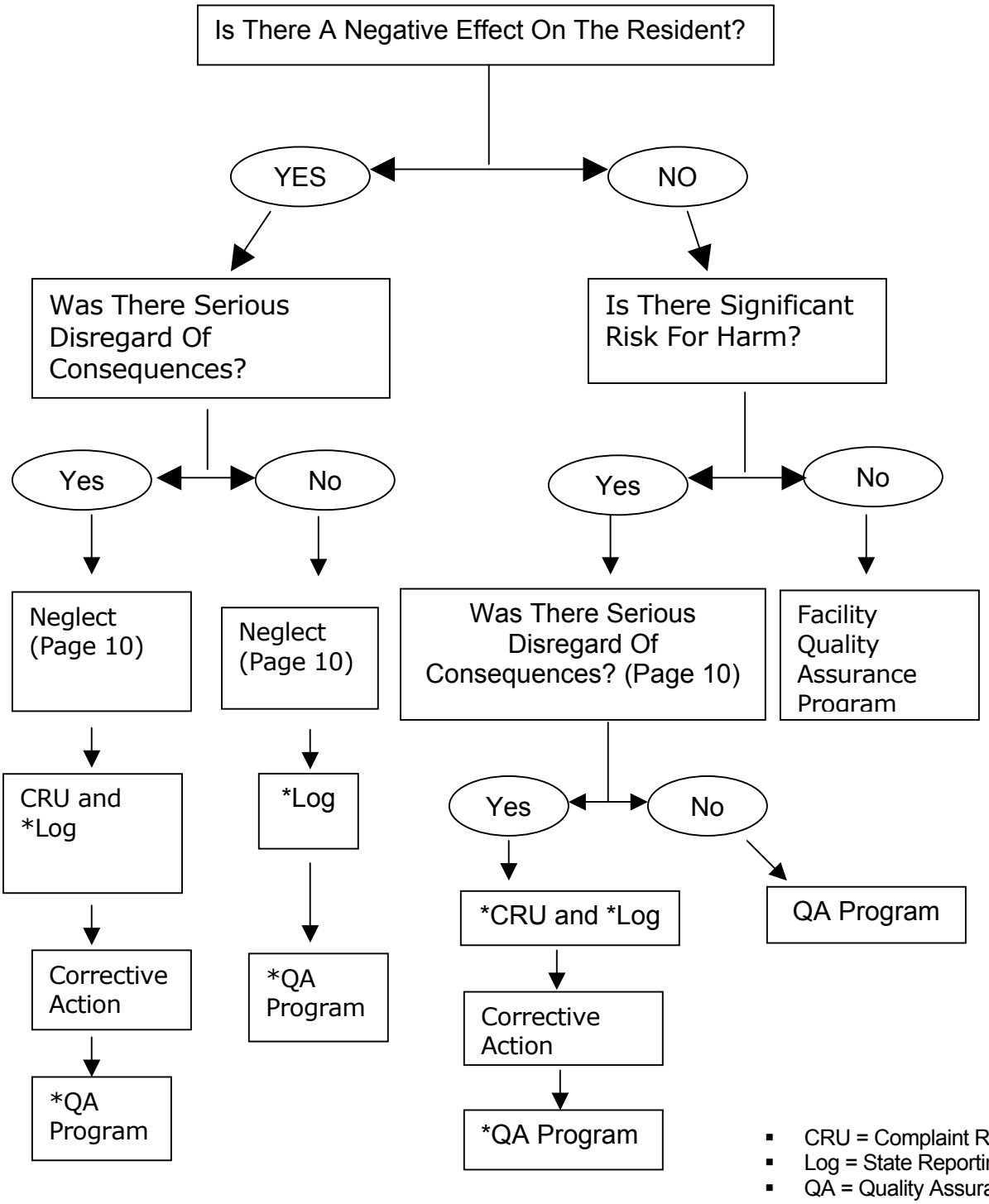
# APPENDIX B

**DEFINITION DIAGRAM - NEGLECT**



# APPENDIX C

**MEDICATION ERROR DECISION TREE**




**It has been the long-standing practice of facilities to have a system for the review of medication errors. It is not the intent of the department to change this system. Facilities should continue to monitor medication errors using their own internal quality assurance program. However, medication errors that are abuse, neglect, or negligent treatment must be reported to the department.**

# APPENDIX D

## REPORTING GUIDELINES FOR NURSING HOMES

| TYPE OF INCIDENT | DSHS Hotline 1-800-562-6078 | DSHS Log Within 5 days | Police | Coroner | Local Health Dept. | DOH | Fire Marshall |
|---|---|---|---|---|---|---|---|
| **STAFF TO RESIDENT**<br>Abuse, neglect, mistreatment, or negligent treatment (except for medication errors – see decision tree)<br>Sexual or physical abuse with bodily harm | X | X | X | | | Xb | |
| **MISAPPROPRIATION/ EXPLOITATION** | X | X | X | | | Xb | |
| **INJURIES OF UNKNOWN SOURCE*****:<br>(Not incidents of abuse or neglect) | | | | | | | |
| ▪ Substantial | X | X | | | | | |
| ▪ Substantial reasonably related | | X | | | | | |
| ▪ Superficial, Unknown | | Xc | | | | | |
| **NON-STAFF TO RESIDENT** | | | | | | | |
| ▪ Abuse/Neglect | Xa | X | X | | | | |
| ▪ Misappropriation/ Exploitation | Xa | X | X | | | | |
| **RESIDENT TO RESIDENT** | | | | | | | |
| ▪ Mental abuse with psychological harm | X | X | | | | | |
| ▪ ****Mental abuse without psychological harm** | | X | | | | | |
| ▪ Physical abuse/abuse with bodily harm | X | X | X | | | | |
| ▪ Physical abuse with psychological harm | X | X | | | | | |
| ▪ **Physical abuse without bodily or psychological harm | | X | | | | | |
| ▪ Sexual abuse | X | X | X | | | | |
| ▪ Misappropriation/ Exploitation | X | X | * | | | | |

**a =** The call to the DSHS Hotline will meet the requirement for reporting to Adult Protective Services (APS), but the facility still may want to contact local APS office.

**b =** Report to the DOH when allegations about licensed/certified health care worker(s) have been substantiated.

**c =** Only those that are unknown after assessment.

*** =** May need to be reported to police.

**** =** In general there is a presumption that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident (whether comatose, cognizant or not) cause physical harm, pain, or mental anguish.

***** =** Repeated injuries, even when related to condition, may become abuse or neglect if preventative measures are not taken.

# APPENDIX D

**REPORTING GUIDELINES FOR NURSING HOMES (continued)**

| TYPE OF INCIDENT | DSHS Hotline 1-800-562-6078 | DSHS Log Within 5 days | Police | Coroner | Local Health Dept. | DOH | Fire Marshall |
|---|---|---|---|---|---|---|---|
| **UNEXPECTED DEATH** | | | | | | | |
| ▪ Possible R/T abuse or neglect | **X** | **X** | **X** | **X** | | | |
| ▪ Suicide | **X** | **X** | **X** | **X** | | | |
| ▪ Not related to abuse/neglect but suspicious | **X** | **X** | | **X** | | | |

OTHER REPORTING REQUIREMENTS FOR NURSING HOMES

| TYPE OF INCIDENT | DSHS Hotline 1-800-562-6078 | DSHS Log Within 5 days | Police | Coroner | Local Health Dept. | DOH | Fire Marshall |
|---|---|---|---|---|---|---|---|
| **Evacuation** | X | X | | | | | |
| **Discontinuance of Services** (such as no food, water, or care supplies) | X | X | | | | | |
| **Transfer/Discharge Notice** | Other* | | | | | | |
| **Communicable Disease Outbreak** | X | X | | | X | | |
| **Fire** | X | X | | | | | X |
| **Explosion** | X | X | | | | | X |
| **Missing Resident** | X | X | X | | | | |

* Send a copy of notice to Field Manager

# APPENDIX E

## REPORTING LOG FORM

***NATURE OF OCCURRENCE**
(Record as many as apply)

01 Fall
05 Medication error
10 Missing Person/Elopement
15 Equipment related or involved
20 Restraint related
25 Dietary related
30 Disaster/major outbreak
31 Evacuation
32 Unexpected death/suicide
35 Resident-to-resident altercation
40 Adverse reaction to medication/treatment
45 Self-inflicted injury +
50 Limb caught in bed, chair, side rail, etc.
55 Injury during handling
60 N/G tube related
65 Property (dentures, etc.)
66 Missing property
70 Other (describe)

***TYPE OF INJURY**
(Record as many as apply)

Substantial
S1 Fractures
S5 Burns
S10 Deep laceration
S15 Bruises of deep color, depth
S20 Area not generally vulnerable to trauma such as face, neck, back, chest, breasts, groin and inner thigh
S25 Other (describe)

Superficial
S30 Surface layers of skin
S35 Abrasions
S40 Lacerations
S45 Small bruises occurring in places generally vulnerable to trauma such as arms, forearms, and shins
S50 Other (describe)

S80 Psychological Harm

***FINDINGS**
(Record as many as apply)

75 Unknown origin ++

80 Origin established
81 Reasonably related to condition
85 Abuse
90 Neglect
95 Not preventable
100 Misappropriation/Exploitation
105 Abandonment

***ACTION TAKEN**
(Record as many as apply)

100 Staff training/counseling
101 Staff employment termination
105 Care plan revision
110 Adaptive equipment
115 First aid
120 Medical treatment
125 Physical plant modification
130 Policy revision
135 No further action
140 Other (Indicate location of documentation

| *DATE LOGGED* | ***RESIDENT NAME*** | ***DATE/TIME OF INCIDENT*** | ****NATURE OF OCCURRENCE*** | ***INCIDENT LOCATION*** | ****TYPE OF INJURY*** | ****FINDINGS*** | ****ACTION*** | ***HOTLINE NOTIFIED YES/NO*** | ***BY WHOM*** |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

***Complete categories with corresponding category number(s) as listed above.**
\+ *Self-inflicted* means the resident was the sole cause of his/her injury.
++ U*nknown origin* -The cause of the incident was not established
+++ *Origin established* – The cause of the incident was established. In establishing the source, the investigator is trying to determine the cause of the incident, not just the injury. For example, observation may establish that lacerations were caused by a fall, but what caused the fall?





Page 30

# APPENDIX F – NURSING HOMES

**STATE HOTLINE QUESTIONS (1-800-562-6078)**

October 2003

To make an official facility report, listen to the main message and then press "2". If you wish to bypass the next menu, press the number that represents the type of incident you will be reporting.

| # | TYPE OF INCIDENT |
|---|---|
| 1 | Follow-up Call |
| 2 | Resident-to-Resident Incident |
| 3 | Staff-to-Resident Incident |
| 4 | Injury of Unknown Source |
| 5 | Resident Fall |
| 6 | Exploitation/Misappropriation of Resident Property |
| 7 | Other Types of Resident Incidents |
| 8 | Medication Error |

**The following standard information is required by facilities making reports to the state hotline:**

**ALL TYPES OF INCIDENTS:**

1. Caller's first and last name:
2. Name of the facility followed by phone number;
3. The name of the resident(s) who is/are involved in the incident;
4. Identify if the doctor and responsible parties were notified of the incident
5. The resident's diagnosis
6. The resident's mental status
7. The resident's ambulatory and transfer status, or if wheelchair bound, identify if the resident self-propels and if he/she was using an assistance device
8. The date and time of the allegation, incident, or injury, **or** the date and time when the allegation, incident or injury was first discovered.
9. Identify if the care plan has changed.

***In addition*** **to the above questions, be prepared to provide the following information when calling to report:**

**FOLLOW-UP CALL – Select 1:**

1. Identify the date of the initial report;
2. Identify the conclusion of the investigation;
3. Identify measures put in place to prevent a reoccurrence.

**A RESIDENT-TO-RESIDENT INCIDENT – Select 2:**

1. Describe the incident and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.
4. Identify if there was evidence of psychological harm.
5. Identify if the incident is isolated or a pattern;
6. Describe the plan to prevent further incidents.

**ALLEGATION OF STAFF TO RESIDENT ABUSE OR NEGLECT – Select 3:**

1. Describe the alleged incident, and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.

4. Identify if there was evidence of psychological harm.
5. Identify the correct spelling and name of the employee(s) including their middle initial;
6. Identify the employee's title and if a nursing assistant, if he or she is certified;
7. Identify the employee's date of hire and date of birth;
8. Identify the employee's social security number;
9. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
10. Identify if the employee has had previous warnings or incidents at your facility;
11. Describe the measures taken to protect the resident during the investigation;
12. Describe measures taken to prevent reoccurrences of the incident.

**AN INJURY OF UNKNOWN SOURCE – Select 4:**

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.

**RESIDENT FALL – Select 5:**

1. Describe other falls within the last 12 months;
2. Identify witnesses;
3. If staff involved, state their name and explain the circumstances.
4. Identify if the care plan was followed at the time of the fall;
5. Identify if motion alarms were in use.
6. Identify the action taken to prevent reoccurrences.

**EXPLOITATION OR MISAPPROPRIATION OF RESIDENT PROPERTY – Select 6:**

1. Describe the details of the exploitation or misappropriation of property including the dollar amount;
2. Identity if local law enforcement has been notified, if so, identify the case number;
3. Identify the alleged perpetrator and identify the person's title or relationship to the resident;
4. If an employee is involved, identify their name including the middle initial, title, date of hire, date of birth and social security number;
5. Identify the action taken to prevent reoccurrences.

**OTHER TYPES OF RESIDENT INCIDENTS – Select 7:**

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.
4. Identify witnesses.
5. Identify the action taken to prevent reoccurrences.

**MEDICATION ERROR – Select 8:**

1. Identify the correct spelling and name of employee(s) involved including their middle initial;
2. Identify the employee's title and if a nursing assistant, if he or she is certified;
3. Identify the employee's date of hire and date of birth;
4. Identify the employee's social security number;
5. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
6. Identify if the employee has had previous medication error incidents at your facility;
7. Describe the medication error. Include the time and date of the medication error, the name and dosages of the medication and when it was discovered.

If you believe there is further information relevant to the incident that is not addressed in the questions outlined, please feel free to leave that information at the end of your call.

# APPENDIX G

### RESPONSIBILITY TABLE

This table serves as a tool to help providers in understanding responsibilities to protect, investigate, report, and prevent abuse, neglect, exploitation, and misappropriation of resident property.

| | NURSING HOME RESPONSIBILITIES | DEPARTMENT RESPONSIBILITIES | *STATUTORY REQUIREMENTS |
|---|---|---|---|
| Protection | ► Safeguard resident(s) from further incident reoccurrence<br>► Treat all consequent ill effects experienced by resident(s)<br>► Provide first aide or emergency medical attention to address any sustained injuries and/or medical/mental problems<br>► Implement facility administrative decisions (e.g. suspension or reassignment of staff during investigation, if necessary) | ► Activate any emergency services to prevent further abuse and safeguard resident(s) general welfare<br>► Protect against dissemination of arbitrary, malicious, or erroneous information or action<br>► Release information in accord with Department rules and Public Disclosure Act<br>► Initiate protective services | ► Vulnerable Adult Act, Chapter 74.34 RCW<br>► OBRA, F223, F224, F225, F226 (CFR 483.13)<br>► WAC 388-97-076(7)(b) |
| Investigation | ► Conduct Phase I investigation within 24 hours<br>► Follow up with Phase II investigation if cause and/or reasonable cause undetermined | ► Initiate Department investigation within 24 hours of receipt of report of allegation<br>► Conduct onsite investigation in accord with Department rules | ► Vulnerable Adult Act, Chapter 74.34 RCW<br>► OBRA, F225 (CFR 483.13 (c)<br>► WAC 388-97-076(7)(a) |
| Reporting | ► * Log in state reporting log abuse, neglect, superficial/substantial injuries of unknown source, misappropriated property<br>► Notify State Hotline of allegations within 24 hours<br>► Notify Administrator immediately of allegations<br>► **Notify police of suspect criminal activity | ► Report allegations to appropriate public agencies, law enforcement, including the Medicaid Fraud Unit of Attorney General Office, if appropriate<br>► Report finding of abuse/neglect to OBRA Nurse Aide Registry and appropriate disciplinary board | ► Vulnerable Adult Act, Chapter 74.34 RCW<br>► OBRA, F225, (CFR 483.13 (c). 488.335<br>► WAC 388-97-076(6)(a)(b) |
| Prevention and Corrective Action | ► Resolve cause<br>► Prevent re-occurrence of incident (e.g. revise plan of care, disciplinary action, education, training, revision of policy/procedure)<br>► Engage facility administrative decisions<br>► Report all suspect incidents of abuse, neglect, exploitation, or misappropriated property | ► Enforce regulations and write statement of deficiencies requiring plans of corrections<br>► Monitor facility practice<br>► File appropriate charges<br>► Issue findings of abuse, neglect, and misappropriated property | ► Vulnerable Adult Act, Chapter 74.34 RCW<br>► OBRA, F225, and other applicable F-tags relative to area of failed practice (CFR 483.13)<br>► CFR 488.335<br>► WAC 388-97-076(7)(b) |

Federal intent is to ensure timely identification, investigation, and prevention of abuse, neglect, and injuries of unknown source.
*Reporting log must be retained in facility.
**The decision to call the law enforcement agency is dependent on whether criminal activity is suspected and immediate action needs to be taken by the law enforcement agency when appropriate. Death due to abuse, neglect, or negligent treatment is a crime. Deaths of indeterminate cause with suspect abuse, neglect, or negligence must be reported immediately to the police.

# APPENDIX H
## Problem Solving Procedures for Facilities Upon Discovery of An Incident/Allegation

**PROTECT * INVESTIGATE * REPORT * CORRECT * PREVENT**

**In general, there is presumption that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident (whether comatose, cognizant or not) causes physical harm, pain, or mental anguish.**

1. Immediately treat ill effects to resident
2. Protect resident against further occurrences
3. Institute other interventions as needed

### PHASE I

1. Begin investigation upon discovery of the incident
2. Gather facts to answer who, what, when, where, how, and why
3. Analyze information to rule out or establish the likelihood that abuse, neglect, exploitation, or misappropriation has occurred, or may have contributed to the incident

NOTE: Report suspected abuse/neglect/exploitation/misappropriation within 24 hours
Record: (1) The details of the incident in the residents medical record(s); and (2) The details of the investigation according to the requirements and facility protocol

Cause identified: Go back to Phase I

d. The cause/circumstance of the incident cannot be determined in Phase I investigation

### PHASE II

1. Gather additional facts
2. Analyze for likelihood of abuse/neglect/ exploitation or misappropriation of resident property

e. Cause of incident still undetermined after Phase II investigation

1. Record details of investigation
2. For a Substantial injury: Call Hotline and Log within 5 days
3. For a Superficial injury: Log within 5 days

a. Substantial injury seems reasonably related to: resident's condition, known & predictable interactions with surroundings, diagnoses, etc. OR a known sequence of prior events

1. Record findings that validate this conclusion
2. For substantial injuries, Log within 5 days

b. There was an unexpected, unusual, unintended event (AN ACCIDENT) & could have been predicted, given prevailing circumstances

1. Record findings that validate this conclusion
2. No reporting in Log or to Hotline is necessary

c. Incident is suspected to be abuse, neglect, exploitation, or misappropriation

**RESIDENT TO RESIDENT**
**Record details of the incident.**
**Report to the department all incidents:**
Of sexual abuse
That result in psychological harm to the victim
Of physical abuse that results in bodily harm to the victim;
That may show neglect on the part of the facility due to the recurrent resident-to-resident incidents.
**Report to law enforcement incidents of:**
Sexual abuse
Physical abuse with bodily harm
**Reporting log within 5 days:**
All incidents

**FAMILY/VISITOR TO RESIDENT**
**Record details of the incident.**
**Report to the department:**
All incidents
**Report to law enforcement:**
Sexual abuse
Physical abuse with bodily harm
Misappropriation/ financial exploitation
**Reporting log within 5 days**:
All incidents

**STAFF TO RESIDENT**
**Record details of the incident.**
**Report to the department:**
All incidents.
**Report to law enforcement:** Sexual abuse; Physical abuse with bodily harm; Misappropriation/ financial exploitation
**Reporting log within 5 days:**
All incidents

1. Act to prevent recurrence of incident and protect resident(s), even if exact cause of incident has not been identified
2. If related to abuse/neglect/negligent treatment/misappropriation, refer to appropriate protective services
3. Do needed re-assessment, care revision, staff training and equipment modification to assure resident's safety


It is the policy of the Department of Social and Health Services that no person shall be subjected to discrimination in this agency or its contractors because of race, color, national origin, sex, age, religion, creed, marital status, disabled or Vietnam Era veteran status, or the presence of any physical, mental, or sensory handicap.